Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

G PETER FOOX MD
1405 S FLEISHEL AVE #330
TYLER, TX 75701

Respondent Name

HARTFORD INS CO OF THE MIDWEST

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-12-0284-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "must be paid according to Fee Schedule [not legible]e DWC fee schedule for 2 body parts shoulder and beck [sic] is 650+150=800.00 I submitted for reconsideration May2011 no response called several times to supervisor Sammy Harrell but she did nothing about paying it Ignored all reasonable attempts at getting paid"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier is in the process of re-evaluating the provider's bill. It will supplement its response upon completion of the review. Otherwise, the carrier relies upon its previously issued EOB."

Response Submitted by: Hartford c/o Flahive, Ogden & Latson, PO Box 201320, Austin, Texas 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 16, 2010	99456-WP	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 15, 2011
   - W1 – WC STATE FEE SCHED ADJUST. REIMBURSEMENT ACCORDING TO THE TEXAS MEDICAL FEE GUIDELINES.

Issues

1. Has the examination for Maximum Medical Improvement (MMI)/Impairment Rating (IR) been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Review of the insurance carrier's position summary on October 10, 2011 states, "The carrier is in the process of re-evaluating the provider's bill. It will supplement its response upon completion of the review. Otherwise, the carrier relies upon its previously issued EOB." The division contacted the requestor on October 21, 2011 to determine if payment had been received by the requestor. There was no additional payment received according to requestor. A follow up request was made prior to this decision with no new information received. MFDR will proceed with audit per applicable fee guidelines.
2. The provider billed $800.00 for CPT code 99456-WP for a MMI/IR exam. Review of the documentation supports that MMI was assigned, Range of Motion (ROM) to bilateral shoulders (upper extremities) and DRE Category II method rating of cervical was performed. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), determines the MAR for an IR using Diagnosis Related Estimates (DRE) IR method as $150.00. 28 Texas Administrative Code §134.204(j)(C)(ii)(II)(a) shows the MAR for one musculoskeletal area ROM method is $300.00.
3. The respondent has reimbursed $350.00 for the MMI evaluation and $300.00 for the ROM to shoulders totaling $650.00. However, respondent has not reimbursed the DRE to cervical spine of $150.00. The combined MAR for the MMI/IR exam is $800.00. Therefore, the requestor is entitled to reimbursement of $150.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 27, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.